+A$4942 (95% CI $3509 to $6375) more in mean total costs compared to cerebrovascular (CerVD) patients respectively. A history of atrial fibrillation (AF), PAD and diabetes was associated with higher resource utilization. **CONCLUSIONS:** Our analysis has found that significant predictors of resource utilization and medical costs were PAD, AF, and diabetes. The results highlight the need for policies that target reducing the number of co-morbidities, which will decrease the incidence of PAD, AF and diabetes in population, given current and projected burden. This data provide the necessary framework for economic evaluations of health interventions.

PCV66

VARIATIONS OF HEALTH CARE CONSUMPTION IN MANAGEMENT OF ATRIAL FIBRILLATION PATIENTS IN THE ACUTE CARE SETTING: THE RHYTHM AF STUDY

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OBJECTIVES: There are few large trials devoted to atrial fibrillation (AF) management in the acute care setting, and no standardized strategy in place. **METHODS:** RHYTHM-AF is a prospective observational study fielded in 10 countries. Patients considered for cardioversion (electrical, ECV or pharmacological, PCV) were enrolled between May 2010 and April 2011 (n = 3397). We compared medical resource (MR) and median lengths of stay (LoS) calculated as discharge minus admission time. **RESULTS:** Patients' serum haemoglobin and creatinine were measured most frequently in Spain (99.4% and 99.0%) and least in the Netherlands (49.7% and 96.7%). Thyroid hormone levels were most often available in Germany (78.6%) and least in Spain (7.3%). Italy, France, Poland and UK performed transthoracic echocardiography commonly (55.5%, 67.7%, 72.1% and 70.4% respectively). Transoesophageal echocardiography was rarely administered, except in Germany (73.1%). Chest X-ray also varied from 95.2% (Spain) to 8.9% (Sweden). LoS varied by region and mode of CV. Australia (66% ECV), the Netherlands (77 %), Sweden (96%) and UK (85%) had LoS < 24 hrs. Among those whose primary mode of cardioversion was ECV, the LoS was highest in Poland (51% ECV) at a median of 54 hours, in Germany (91%) at 53 hours and in France (81%) at 46 hrs. Among those on PCV, France (20%) and Australia (35%) had the highest LoS at 192 and 140 hrs, respectively; the Netherlands (23%) and Spain (79%) the lowest, at 5 and 10 hrs. **CONCLUSIONS:** There is regional variability in MR and LoS among AF patients. Several patient-, physician-,and/or environmental- level factors may contribute to this variation. Further research examining factors which may contribute to and result from extensive hospital stays and diagnostic procedures and to assess whether the variability of these are associated with one another is warranted to further inform clinical practice and quality of care.

PCV67

PHARMACY COST SHARING, ANTIPLATELET THERAPY UTILIZATION, AND HEALTH OUTCOMES FOR PATIENTS WITH ACUTE CORONCARY SYNDROME

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OBJECTIVES: To examine how cost sharing for prescription drugs affects compliance with antiplatelet therapy and subsequent health outcomes among patients with acute coronary syndrome (ACS). **METHODS:** A retrospective outcomes study using administrative data from medical and pharmaceutical claims of patients enrolled at health plans offered by 26 large employers drawn from all regions of the country. A total of 14,325 patients were diagnosed as having ACS and underwent coronary stent implantation between 2002 and 2005. Each patient was followed up for a maximum of 2 years. Primary outcomes measures were adoption of outpatient antiplatelet therapy, adherence to outpatient therapy, hospital admissions, and healthcare expenditures. **RESULTS:** Patients with ACS who face higher coinsurance are less likely to adopt outpatient antiplatelet therapy within the first month after stent implantation and are more likely to discontinue treatment in the first year after stent implantation (P <0.01). Higher coinsurance is also associated with an increased number of ACS rehospitalizations (P <0.01). For patients in health plans with higher coinsurance rates, expected costs from ACS hospitalizations are $2796 (38%) higher in the first year after stent implantation (P <0.01). **CONCLUSIONS:** Higher copayments for prescription drugs are associated with lower utilization of antiplatelet therapy and with higher likelihood of rehospitalization among patients with ACS. As a consequence, total healthcare spending for patients with ACS increases by approximately $615 in the first year after stent implantation.

PCV68

UNIT COSTS ESTIMATION OF POST-STROKE DYSPHAGIC PATIENTS IN THE USA

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OBJECTIVES: Dysphagia is a frequent complication occurring after stroke as a consequence of neurologic lesions at stake in controlling swallowing reflexes. Unmanaged dysphagia has been associated with an increased risk of aspiration pneumonia and even mortality. Alongside morbi-mortality, dysphagia has also been shown to increase inpatient length of stay. This often leads to incremental inpatient costs of care directly or through its complications. This study aimed at gathering unit costs related to dysphagia for stroke patients. **METHODS:** A combined literature and expert-based costing study was carried out for the following dysphagia cost items: screening, severity staging, rehabilitation and pulmonary complications. These costs were primarily estimated based on medical fees and technical procedures billing. 2011 US unit costs and charges according to Medicare perspective were estimated. **RESULTS:** Early bedside screening and Speech Language Pathologist (SLP) based clinical assessment ranged between USD 16-26 and USD 40-105 respectively. Instrumental severity staging by either Videofluoroscopy, or Fiberoptic Endoscopic Evaluation (with sensory testing or not) was estimated to fall between USD 331-348. Swallowing disorder rehabilitative session mediated by an SLP is charged around USD 94. Inpatient costs related to aspiration pneumonia secondary to post-stroke dysphagia were estimated to range between USD 19,509 - 22,714. **CONCLUSIONS:** This study demonstrated the potential economic benefits of any intervention aiming at reducing the risk of aspiration when considering the high costs of associated pneumonia.

CARDIOVASCULAR DISORDERS – Patient-Reported Outcomes & Patient Preference Studies

PCV69

VARIANCE IN MEDICATION ADHERENCE BY PATIENT BEHAVIORAL SEGMENT: A MULTI-COUNTRY STUDY IN HYPERTENSION

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OBJECTIVES: The objective of this study was to determine the prevalence of patient behavioral segments and medication adherence levels by segment for a hypertensive patient population. **METHODS:** Members from MediGuard.org and other online patient panels in the UK, Germany, Italy, and Spain were invited to participate in a web-based survey that included: a patient segmentation instrument developed by CoMac Analytics based on a linguistic analysis of patient talk and the MARS-5 adherence instrument. Subjects were screened to have a diagnosis of hypertension and treatment with at least one anti-hypertensive agent. **RESULTS:** 353 patients completed the on-line survey in August/September 2011 and were categorized against three different behavioral domains: control orientation [176 (50%) I=internal, 177 (50%) E=external], emotion [100 (28%) P=positive, 253 (72%) N=negative], and agency or ability to act on choices [227 (64%) H=high agency, 126 (36%) L=low agency]. Domains were grouped into 8 different clusters with EPH and IPH arising as the most common (88 respondents (25%) in each cluster). The prevalence of other behavior clusters ranged from 6% (22 respondents, INH) to 12% (41 respondents, IPL). The proportion of patients defined as adherent (scored 25 on MARS-5) varied sharply across the segments: 51% adherent (45 of 88 respondents) for the IPH vs. 8% adherent (2 of 25 respondents) classified as INL. Side effects, being employed, and stopping medicine because the patient got better were all significant determinants of adherence in a probit regression model. **CONCLUSIONS:** By categorizing patients into worldview segments, we identified wide differences in adherence that can be used to prioritize interventions and to customize adherence messages.

PCV70

EXAMINING MEDICATION ADHERENCE AND LOW DENSITY LIPOPROTEIN-CHOLESTEROL (LDL-C) GOALS AMONG TRICARE BENEFICIARIES RECEIVING STATIN THERAPY FOR SECONDARY PREVENTION OF CORONARY HEART DISEASE IN US MILITARY TREATMENT FACILITIES

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OBJECTIVES: To examine statin adherence and LDL-C targeted treatment goals (TTGs) among TRICARE beneficiaries receiving treatment for secondary prevention of coronary heart disease (CHD) at US Military Treatment Facilities (MTFs). **METHODS:** Retrospective cohort database study examining TRICARE beneficiaries 18-75 years of age, receiving medical services for a primary CHD event at an MTF between Jan-1-2004 and Dec-31-2008. Of the 20,658 MTF patients receiving statin-therapy for CHD, 3,676 had an LDL-C value recorded during subsequent 6-month (M6), 12-month (M12) and 18-month (M18) periods. TTGs were defined using ATPIII-NCEP Guidelines (i.e., LDL-C value<100mg/dL). Drug adherence was measured using the Medication Possession Ratio (MPR) at M6,M12, and M18. Persistence was measured as time to >35-day refill gap. Covariates included age, gender, beneficiary status, comorbidities, statin switching, dosage titrations and other lipid lowering therapies. Logistic and Cox regressions were conducted to assess predictors of TTG and adherence/persistence. **RESULTS:** The CHD cohort was 75% male, mean age 58.8 (SD=9.3) years. The percent of patients adherent (MPR>0.80) with statin-therapy was 85% at M6, 79% at M12, and 78% at M18. Older diabetic patients were more adherent and at TTG. Adjusting for covariates, adherent patients were more likely to be at TTG in M6,M12, and M18 (OR=1.98[1.62-2.42], 2.69[2.25-3.22], and 2.93[2.44-3.52], respectively). Overall mean persistence to statins was 330 (SD=199) days. Approximately 68% of patients were persistent at M6, 50% at M12, and 37% at M18. Patients at TTG were less likely to experience a gap in therapy at M6,M12, and M18 (HR=0.83[0.78-0.89],0.80[0.76-0.84], and 0.80[0.77-0.84]). **CONCLUSIONS:** This study showed a positive link between statin adherence and TTGs among secondary prevention patients with frequent LDL-C monitoring in the MHS. Patients with better adherence to statin-therapy were more likely to be at TTG, compared to non-adherent patients. Further study is needed to assess generalizability to all MHS secondary prevention patients.